VSH Futures Project
From February 4 2005 Report from Charlie Smith to Legislature

To ensure appropriate utilization of these beds, this plan calls for the development of a care management system.

Care Management System

In Vermont's health care system, no patient is turned away from a hospital because their illness is "too acute," and, in turn, no one hospital is expected to provide all services, all the time. Instead, through a system of internal management, clear definition and expectations for each hospital's role, and triage conventions, our hospitals collectively assure that all Vermonters in need of inpatient care receive that care. This network of collaborating partners to be implemented in Vermont for acute psychiatric care is similar to the collaboration that occurs in general health care among hospitals, rehabilitation services and outpatient services.

The yet-to-be-selected participating partners will develop a common, standardized definition for each of these levels of care. Each program will be understood to fulfill a particular role in the system. Pending legislative approval of this approach, a workgroup comprised of consumers, clinicians and administrators will be convened to develop a single set of admission, continued stay, and discharge criteria for each type of program. In other words, a common standard will be developed to determine admission to any of the 126 psychiatric inpatient beds, or the 19 crisis stabilization/inpatient diversion beds. Vermonters needing acute care will have access to the whole continuum of services and the participating partners will agree to collaborate to ensure that the available bed capacity is adequate to meet the needs of clients.

Creating an Interdependent System of Inpatient Care

DHs are indispensable in providing urgent specialty psychiatric care within the public mental health system and further the goal of providing each individual with quality treatment as close to home as possible. Currently, they function cooperatively but not interdependently. The following changes are necessary to support transformation to an interdependent system:

- Explicit standardized admission criteria for general, specialized and intensive levels of care need to be developed and adopted by all DH's.
- Best practice standards and clinical systems must be adopted by all DHs.
- A no-rejection policy must be adopted by each DH for individuals who meet criteria for involuntary *general* inpatient care from *within the area* served by that hospital.
- A no-rejection policy must be adopted by all DHs who provide *specialized* and/or *intensive* treatment statewide.
- A centralized information system must be developed and implemented to provide clinicians in the field with instant information about available resources at the time a need for hospital diversion has been determined. Clinicians should be able to complete a simple internet transaction or make a single call and enable patients to move quickly to an appropriate site for treatment without long waits in the emergency rooms.

• An information management system must be implemented in which data collection is streamlined, focused, and made consistent across all designated agencies for comparable service lines. This system must be implemented in such a way that performance and cost measures are relevant and comparable across the system to achieve consistency is achieved in the evaluation of therapeutic thresholds, and in the design and cost of service plans for individuals with equivalent levels of need across the state.

The Qualified Mental Health Professionals (QMHPs) will authorize entry to the network. This will necessitate a change in the role of the QMHP from the more narrow screening and gate-keeping function to include a more robust assessment function in which the QMHP will recommend the level of care and program that is most appropriate to meet an individual's needs, based on the clinical presentation, and the use of standardized instruments, trauma-informed best practices, availability of peer and staff resources, and the available resources in the person's personal network. Screening protocols for trauma and substance abuse in addition to mental illnesses will be universally implemented. This will necessitate and the development of clear performance standards and an enhancement in the level of expertise, training and oversight of this key position
In order to handle their expanded role, the QMHPs will need the following resources and capacities:

• statewide access to a continuum of acute care services (crisis stabilization/inpatient diversion beds, psychiatric inpatient, specialized inpatient, and psychiatric ICU beds).
• an information system capable of tracking utilization and availability of beds
• availability of safe, timely and appropriate transportation of individuals between programs.

In addition, in order to provide appropriate services to all individuals – but especially those who have experienced trauma, the QMHPs need to be able to assure physical and emotional safety (see Triage Capacity proposed below) and to be able to offer a range of options that maximizes choice and control for individuals being served.
The use of standardized placement criteria (admission, continued stay, and discharge) will be monitored by a small team of VDH staff. Their role will resemble the current VSH acute care team in that they will facilitate resolution of systems issues, assure connections with ongoing care, and ensure that the various system components and programs work together as needed. In addition, the role will expand to include working with the partnering programs on proactively managing bed use to ensure that service capacity is available when needed. Census management protocols will be developed with each participating partner and these would be implemented by the local programs with the assistance of the acute care team.
This system will also require that an appropriately clinically empowered systems administrator be available at all times (24/7) to consult with QMHPs regarding placement recommendations and to facilitate access to needed levels of care. The recommendation of this plan is that the administrator role be rotated among all the participating partners.

For instance, on a quarterly basis, the role will shift to a different provider, ensuring that each gains experience in the triage operations of the whole network.
As this process further evolves several infrastructural components will need to be in place. These are:

- *Client level service encounter data system* with timely reporting and appropriate HIPPA compliance by all service providers. In turn, the Mental Health Authority needs adequate information technology (IT) capability to assure data integrity, develop regular and ad hoc management reports, and to create new programming as needed.
- *Business Office* and *Financial Reports* to oversee the fiscal health of the service system, to account for the public resources invested, and to investigate and report on the real costs of providing services
- *Legal Service* to insure that clients' rights are protected, that the custodial role of the state is appropriately carried out, and to insure that clear and enforceable contracts with service providing partners are developed and maintained.
- *Clinical Management* to design standardized protocols governing the flow of patients through the system, to consult in complex issues of patient care, and to evaluate the quality of the services being rendered by participating partners.
- *Program Development and Evaluation* to guide program implementation, to evaluate the effectiveness of existing programs and to identify new service approaches for adaptation and use in Vermont .
- *Quality Management Quality Improvement system* To identify clear outcomes for each component of the services system, to measure progress to those outcomes, to benchmark outstanding results, to implement plans of improvement and correction as needed, and to design new approaches and systems to improve clients outcomes

Challenges:
There are many challenges in attempting to realize this vision of decentralized, community-based care. Central among these is the need to ensure that patients have access to high quality state of the art care, access to research initiatives, receive adequate and appropriate information about their rights, meaningful access to legal representation, and full protection and enforcement of advance directives. The legislative intent of Act 114 is explicit in its unqualified support for protected decision making when competent: *"It is the intention of the general assembly to recognize the right of a legally competent person to determine whether or not to accept medical treatment..."* 18 V.S.A. § 7629. Not only are all physicians and health care providers bound to follow the directives of a designated agent; the health care provider is required to *"develop systems to ensure that a patient's advance directive is promptly available when the patient is to receive services from the provider."* (Act 162, 2004)
We propose to ensure quality and safeguard rights through:

- Appropriate credentialing
- Utilization of best practices
- Academic affiliation
- Consumer and family involvement in systems planning and design

- creation of a treatment options work group to further develop recommendations for both community and hospital treatment alternatives.
- consistent training and oversight at all sites for involuntary procedures, whether involving involuntary, voluntary, general hospital patients or corrections inmates for whom added involuntary procedures related to mental illness are used.
- implementation of the statutory revisions directing that less traumatic forms of involuntary transport be used when consistent with safety and that the ability to access alternatives that are developed regarding inter-hospital transfers will be enhanced by the planning time permitted by use of pre-admission emergency triage beds.
- implementation of improved monitoring of involuntary interventions, including close review of actual “best practice” facilities and equipment for safety in restraint and seclusion.